

OPPENHEIMER (S.)

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CARTILAGINOUS DEFLECTION
OF THE NASAL SEPTUM.

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THE ADVOCATION OF A NEW METHOD OF OPERATION FOR MARKED DIFFUSE CARTILAGINOUS DEFLECTION OF THE NASAL SEPTUM.*

BY SEYMOUR OPPENHEIMER, M. D.,
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THE subject of septum deviation is such an important one that I could not do it justice in the few moments allotted me for its resumé and discussion, and particularly as it is more or less a specialistic topic, it might be somewhat out of place at a meeting of this kind. I will therefore confine myself very briefly to those points, directly advancing the method of operation under discussion.

During the past few years, innumerable orthopedic and operative methods for the correction of cartilaginous deviations of the septum of a high degree have been advocated by various operators and authors. The general results of these various methods have been, as far as I learn, far from satisfactory.

In the last year I have operated upon six cases of marked deflection, all due to trauma, in which the greatest portion of the cartilaginous septum was involved. In one I endeavored to correct the deformity by gradual dilatation with bougies, but after several months of perseverance without accomplishing much, the patient became discouraged and passed from under my observation. In three other cases I refractured the septum, and by means of splints held it in position. The immediate results appeared to be very satisfactory, but upon seeing the patients, some eight months subsequent to the operation, I

* Read at the eleventh annual meeting of the Fifth District Branch of the New York State Medical Association, Brooklyn, May 28, 1895.



found that there was a decided tendency for the deformity to return. In the remaining two cases I made a crucial incision, followed by forcible correction of the deflection, and although this procedure did not accomplish all that might be desired, much improvement was derived.

Recently, while in Vienna, I had the opportunity of observing eleven cases of septal deformity operated upon by a method proposed by Dr. Hajek. The results were very encouraging. In all the cases, nasal respiration was established and no external deformity occurred.

During the fall of 1892 and spring of 1893 fourteen cases had been operated upon. In none of these cases had there been any return of the nasal deflection up to the time of examination, December, 1894.

Upon March 24, 1895, A. H., 38 years of age, consulted me, giving the following history: One year previously she was struck upon the nose very forcibly by a baseball. Her physician ordered cold applications and lead and opium solution, under the influence of which the inflammation rapidly subsided, and, excepting for the discomfort of obstructed nasal breathing, she felt comparatively well. For the following six months she had repeated attacks of rhinitis, accompanied with profuse secretion. Consulting a specialist, he made six distinct applications of the galvano-cautery to the right inferior turbinated body at various sittings. His opinion, and also that of a consultant, as to the amount of benefit to be derived from operative interference upon the deflected septum was so dubious, that she decided to postpone it until some future time. Following the cauterization, the nose, which formerly secreted so profusely, assumed a dry condition, with a gradual increasing amount of scab formation, which gave rise to a very disagreeable odor. For this she was again treated, and by the regular use of the spray the nose is kept in a fairly clean state. Upon examination, I find upon the right side an enormous concavity with a marked atrophic condition of the turbinated bodies. Upon the left, the septum is pushed so much laterally that it impinges upon the turbinated bodies, having caused a degeneration of their structure. The entrance of air into this side is practically impossible.

A similar condition of atrophic degeneration was present in the post-nasal space and upon the posterior pharyngeal wall. The patient requesting that something be done for the relief of the nasal obstruction which was developing most unpleasant symptoms, par-

ticularly those referable to aural disturbance, I decided to interfere operatively, but being particularly cautious to inform the patient that I could not forsake the amount of good to be derived.

Upon the following day I operated upon her, the various steps in the procedure being as follows: The nose was disinfected with a spray of a weak creolin solution, also saturating several pieces of cotton with it, which were allowed to remain in position for several minutes. After their removal the posterior nares were plugged, so that there would be no possibility of the blood flowing back into the pharynx during the operation; the patient's attempts at expectoration would have retarded the progress of the operation considerably. Pledgets of cotton saturated with a 10% solution of cocain were then introduced into both nostrils, pressing them firmly against the septum. After ten minutes they were removed, and the parts were found to be thoroughly anesthetized.

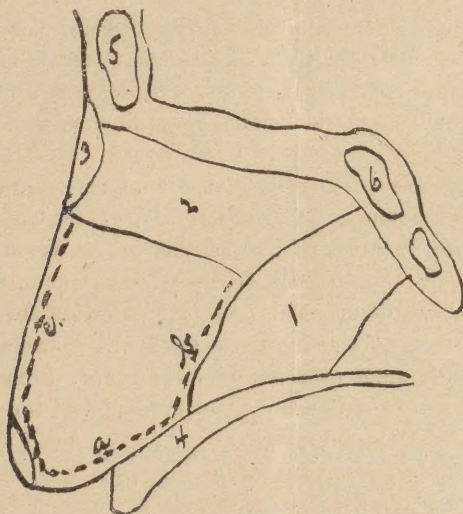


FIG. 1.

Sagittal section of the nose (diagrammatic). A, B, C, lines of incision: 1, vomer; 2, ethmoidal plate; 3, nasal bone; 4, superior maxillary bone; 5, frontal sinus; 6, sphenoidal cells.

An incision (a) was then made with a slender sharp-pointed knife through the antero-inferior border of the cartilaginous septum (through its entire thickness). The incision was continued horizontally backwards and slightly upwards, with a blunt knife, along the juncture of the lower cartilaginous septal border with the spina nasalis of the superior maxilla as far back as the articulation of the vomer.

A right-angular knife was then substituted for the straight one, and the incision prolonged upwards and slightly forwards for about $1\frac{1}{2}$ cm. (b). Then the incision is made from the starting point of the first incision, *i. e.*, antero-inferior septal border, and carried upwards parallel with the external contour of the nose until the lower edge of the ethmoidal plate is reached (c).

These three incisions having been made, the cartilaginous portion of the septum is now converted into a movable fragment, attached only at the upper part.

By using a little pressure the septum can now be dislocated from the convex to the concave side, and held in its new position by some form of splint. The tampons in the posterior nares now being removed, the operation is complete.

Hajek¹ made use of iodoform gauze tampons, which I have replaced by splints, as recommended by Berens²

Little pain was experienced by the patient and the hemorrhage, although considerable, stopped of its own accord. The splints were left undisturbed for one week, when they were removed and the nares thoroughly cleansed and the splints re-introduced, being allowed to remain in position one week longer, after which they were discarded.

On April 12, three weeks after operation, the wounds had entirely healed. There was some obstruction due to redundant tissue, occupying the inferior meatus. This was removed by means of the saw. The patient could then breathe freely through the nostril, and the symptoms of aural disturbance, *i. e.*, pain, tinnitus, deafness, which previously existed, have entirely disappeared. The knives used for the operation were made after the models of Prof. Jurasz,³ of Heidelberg, their original intention being for resection of the septum.

¹ Hajek, *International Klinische Rundschau*, No. 38.

² *Manhattan Eye and Ear Hospital Reports*, 1894.

³ *Die Krankheiten der oberen Luftwege*, page 70.

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